**Conclusions**: Following the introduction of this policy, there was no increase in the percentage of negative appendicectomies, wound infections or intra-abdominal collections. While acknowledging that the numbers in this early audit were small, we feel they demonstrate a convincing trend. The introduction of the policy enabled a standard of care to be set, did not adversely affect our rate of negative appendicectomies, and may prevent leaving histologically abnormal appendixes in situ.

### 0999: TRAINING A UK TRAUMA SURGEON: LESSONS FROM USA, CANADA, AUSTRALIA AND SOUTH AFRICA – A SURVEY OF TRAUMA TRAINEES AND TRAINERS

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**Introduction**: This survey was directed at trauma surgeons from major trauma centres in South Africa, USA, Australia and Canada, to evaluate their training and hypothesise a potential pathway for training British trauma surgeons.

**Methods**: A two-part survey was designed; the first evaluated local training structure, formal training received and procedures performed. The second part focused on designing a trauma training programme for UK surgeons, including ideal length of training, relevant specialty rotations and most appropriate certification method.

**Results**: Twenty-eight trauma surgeons were surveyed (13 South African, 10 American, 4 Australian and 1 Canadian). All respondents received formal training in Advanced Trauma Life Support, critical care (mean 5.8 months, SD±3.8) and trauma surgery (mean 11.8 months, SD±7.1). 90.5% had formal training in damage control surgery. 89.3% believed trauma training should start after 2 years of surgical training. Top essential rotations were critical care (67.9%), trauma (64.3%), general surgery (57.1%) and vascular surgery (39.3%). For accreditation, 53.6% recommended international fellowship, 18% research fellowship, 85.7% theory exam, 82% certain index cases, 75% viva examination, 75% competency assessment, and 71.4% logbook assessment.

**Conclusions**: Lessons learnt from countries that have formalised trauma training can be applied to the designing of UK trauma surgery training pathway.

### 1021: PREDICTING ACUTE APPENDICITIS? A PROSPECTIVE COMPARISON OF THE ALVARADO SCORE, THE APPENDICITIS INFLAMMATORY RESPONSE SCORE AND CLINICAL ASSESSMENT

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**Introduction**: The Appendicitis Inflammatory Response (AIR) score has outperformed the Alvarado score in two retrospective studies. This study prospectively evaluates the AIR Score and compares its performance to the Alvarado score and initial clinical impression in predicting risk of appendicitis.

**Methods**: Parameters in the AIR and Alvarado scores and the initial clinical impression of a senior surgeon were prospectively recorded on patients with acute right iliac fossa pain. Predictions were correlated with the final diagnosis.

**Results**: Appendicitis was diagnosed in 67 of 182 patients. The three methods of assessment stratified similar proportions (~40%) of patients to a low probability of appendicitis ($p=0.233$). The false negative rate (<8%) didn't differ between the AIR score, Alvarado score or clinical assessment. The Alvarado score assigned the highest proportion of patients to a high probability of appendicitis (45%,$p<0.001$). A high AIR score was associated with high specificity (97%) and positive predictive values (88%) but a lower specificity (33%) than the Alvarado score (80%) or surgical assessment (63%).

**Conclusions**: The AIR score is accurate at excluding appendicitis in those deemed low risk and in predicting it in those deemed high risk. Its use as the basis for selective CT imaging in those deemed medium risk should be considered.

### 1045: WHEN DO WE NEED TRAUMA SURGEONS? – AN OBSERVATIONAL STUDY OF ADMISSIONS TO A MAJOR TRAUMA WARD

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**Introduction**: The Major Trauma Ward at St Mary's Hospital, London's North-West Major Trauma Centre, is a specialist ward caring for seriously injured patients. It is staffed by a consultant-led multidisciplinary major trauma and neurosurgical team. We performed an observational study to characterise admissions to the ward.

**Methods**: All admissions to the ward during September 2013 were studied, including demographics, timings, injury pattern and length of stay.

**Results**: There were 90 admissions (mean 3/day), with weekends busier (up to 8 admissions/day on Sundays). 76% of admissions occurred out of hours. The median injury severity score (ISS) was 12 (IQR 4-22). 24% of patients suffered polytrauma and 36% had psychiatric or medical comorbidities. The median length of stay on the ward was 3 days (IQR 1-5).

**Conclusions**: This study suggests implications for the staffing of Major Trauma Centres. The majority of trauma patients were admitted out of hours, with significant injuries and co-morbidities. Consultant in-hospital presence is a scarce resource, and the number of out of hours ward admissions suggest this resource could be most beneficial at times other than Monday-Friday 8am-5pm. The input of a dedicated medical and psychiatric liaison team could also enhance the care and discharge of trauma patients.

### 1083: CORRELATION AND DIAGNOSTIC ACCURACY OF CT IN THE ACUTE SURGICAL PRESENTATION

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**Introduction**: CT utilisation in acute surgical presentations has increased with technological advancement and availability. The on call radiologist of varying seniority reports emergency CT. We undertook a retrospective study comparing the correlation with the initial senior clinicians' diagnosis and laparotomy findings.

**Methods**: Data were collected via standard proforma for 100 sequential acute admissions that underwent emergency CT followed by laparotomy since August 2013. Patients characterised according to gender, age (age >70 years defined as elderly) and ASA.

**Results**: Four patients were excluded with incomplete data. Mean age was 63 years, trending to younger group (60%). Median ASA for the young cohort was 2 and elderly cohort 3. Within the <70 year olds, clinical diagnosis and CT had a positive correlation in 57.1% (32/56) and with laparotomy 53.6% (30/56). CT scan correlated directly with laparotomy 84% (47/56). Within >70 year olds, clinical diagnosis and CT had positive correlation in 57.5% (23/40) and with laparotomy 62.5% (25/40). CT scan correlated directly with laparotomy 85% (34/40).

**Conclusions**: CT accuracy is greater than initial clinical diagnosis; however, there are marked differences in CT and operative findings. This is a pilot for a prospective large trial to evaluate the requirement for acute GI radiology reporting.

### 1088: IS AMYLASE A USEFUL MARKER IN DIAGNOSING APPENDICITIS?

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**Introduction**: Acute appendicitis remains the most common surgical emergency. Diagnosis and decision is based on clinical assessment and investigations. Inflammatory and biochemical markers are important tools in the diagnosis. Raised amylase can occur in various intra-abdominal pathologies. Our aim was to identify if raised amylase was accurate in confirming appendicitis.

**Methods**: A retrospective case note review of all appendicetomies performed in our trust between 2011 – 2013 was carried out. Using a proforma, data was extracted on demographics, blood results, type of operation, operative findings, and final histology.

**Results**: 584 appendicetomies were performed. Overall histology positive for appendicitis were found in 453 (77.5%). Amylase was tested on 389 pts in total. This was raised (>120 units/L) in 7 patients and normal in 382 patients. Of those with histologically confirmed appendicitis amylase was tested on 300 patients. This was found to be raised in 5pts(1.6%), and normal in 295 pts (98.4%).

**Conclusions**: Of those that had histologically confirmed appendicitis only 1.6% had raised amylase. 98.4% had normal amylase levels. Based on these results we believe that amylase is not a useful marker in diagnosing acute appendicitis. However larger patient numbers would be recommended to confirm these findings.